

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked Q item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 00-00330 1D 8 6 0 8 5 5 1
1 - STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST ESTELLA	MIDDLE COATES	LAST BALDWIN	2a DATE OF DEATH MONTH DAY YEAR 3 11 86
3 SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 28 02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse
13a STATE Maryland		13b COUNTY Howard		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13c CITY OR TOWN Columbia				13e STREET ADDRESS / ZIP CODE 10850 Green Mt. Circle 21044	
14 FATHER'S NAME FIRST George		MIDDLE	LAST Baldwin	15. MOTHER'S MAIDEN NAME FIRST Eva MIDDLE Coates	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 219-36-8612		17 INFORMANT Ann Mech 5244 Kalmia Dr. Dayton, Md. 21036	
18 CAUSE OF DEATH (Enter only one cause per line for a, b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) Chronic obstructive pulmonary disease		YEARS			
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure		YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from March 11 1986 Dec 19 85 to March 11 1986 that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jerry L. LEVINE, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22e. DATE SIGNED 3-11-86			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/15/86	23c NAME OF CEMETERY OR CREMATORIAL Grace Esp. Ch. Cem.		23d LOCATION CITY OR TOWN Elkridge COUNTY Howard STATE Maryland
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.	25a DATE REC'D. BY REGISTRAR MAR 14 1986		25b REGISTRAR'S SIGNATURE John J. Sander
(VRA 15, 4)					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-trust permit. Then please remove the carbon copies. Pages 1 and 2 should be filed within 72 hours after the death.

IMPORTANT: If Item 21 is marked  show any injury, or other traumatic event, the medical examiner must be named at once.

## MEDICAL CERTIFICATION

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 6 5 8

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Jonathan Bland</i>						<i>3/21/86</i>				<i>15:48 PM</i>	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 23 HRS.	
<i>male</i>		<i>white</i>	MONTH	DAY	YEAR	<i>68</i>	MONTHS	YEARS	MONTHS	YEARS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Pennsylvania</i>		<i>U.S.A.</i>					<i>Howard</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
<i>Columbia</i>		<i>Howard County General</i>			<i>Retired</i>		<i>011 Co.</i>				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
<i>MD.</i>		<i>HOWARD</i>	<i>Columbia</i>					<i>10569 Jason Lane 21044</i>			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
<i>Jonathan R Bland</i>					<i>Charlotte Allcutt</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YEAR, NO. OR UNKNOWN) <input checked="" type="checkbox"/> YES		16b. SOCIAL SECURITY NO. <i>W 11 199-035-031</i>			17. INFORMANT		ADDRESS				
					<i>M's Elizabeth Bland</i>		<i>10569 Jason Lane Columbia 21044</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ischemic bowel</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24-48 hrs</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Stage D prostate cancer</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>ASCVD</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/20/86</i> , 19, to <i>3/21/86</i> , 19, that (I) (we) last saw the deceased alive on <i>3/21/86</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Say Mills</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/21/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>March 24' 86</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Meadowridge</i>		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Harry H Witzke &amp; Family Funeral Home Inc 4112 Old Columbia Rd Ellicott City</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 25 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Pendale</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon paper. Return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 0 0 8 0 5 4									
1 - STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR					
Montford						Brown			03		31	86		M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		Neg		MONTH DAY YEAR			58			MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
Ala.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard Co.			MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Columbia		Howard County General Hosp								Police Off				Law Enforcement					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE									
Md		Howard		Columbia			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4951 Moonfall Way 21044									
14. FATHER'S NAME		FIRST MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST									
Thelmen				Brown			Connie			Saunders									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			17. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
yes		46-47		220-14-2202			Mrs. Florine Brown			4951 Moonfall									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____																			
DUE TO, OR AS A CONSEQUENCE OF (b) _____																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____																			
DUE TO, OR AS A CONSEQUENCE OF (c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
19a										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M. HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from on 3/31 1986 to 19 19 , that (I) (we) last saw the deceased alive on 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Gershon										DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/31/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Terri Gershon MD										22e. ADDRESS H.C.G.H. Emergency Room									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE								
Burial		4-5-86		Arbutus			Balto				Md.								
24. FUNERAL DIRECTOR NAME _____ ADDRESS _____										25a. DATE REC'D. BY REGISTRAR APR 02 1986		25b. REGISTRAR'S SIGNATURE John Gershon							
BP _____																			
DHMH - T6 60M 7/84 (VRA 15, 4)																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the medical examiner until a final report is issued.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 00-00806	
1. DECEASED NAME (TYPE OR PRINT) <b>Mrs. Leah K. Brumbaugh</b>				2a. DATE OF DEATH <b>March 17 1986</b>				2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>April 5 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		7. IF UNDER 1 YEAR MONTHS <b>YRS.</b>		8. IF UNDER 24 HRS HOURS MIN. <b>0000</b>	
9a. BIRTHPLACE COUNTRY <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Extended Care Facility</b>		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>7002 Clays Lane Apt. 215</b>		ZIP CODE <b>21207</b>	
14. FATHER'S NAME FIRST <b>Robert John Woodrig</b>		MIDDLE <b></b>		LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST <b>Edith Mary (Unknown)</b>		MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-12-9963</b>		17. PERSON ADDRESS ADDRESS <b>4022 Chatham Road</b>		18. PERSON ADDRESS ADDRESS <b>Ellicott City Maryland</b>		21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) { DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cerebral vascular disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>MAURER</b>		21f. LOCATION STREET <b>86</b>		CITY OR TOWN <b>MAR 17 86</b>		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 17 1986</b> to <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Leah K. Brumbaugh</b>						22c. DATE SIGNED <b>3/18/86</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAURER</b>		22e. ADDRESS <b>11085 LITTLE PAT. Pkwy Columbia</b>									
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>3-20-86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Woodlawn</b>		BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Loring Byers</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left attached for 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, then medical certification is required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												0 0 0 8 0 6 1			
1. FOR STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Alice</i>	MIDDLE (mn)	LAST <i>Buono</i>	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR						
3. SEX		4. RACE	5. DATE OF BIRTH MONTH 01 - DAY 06 - YEAR 35			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 51 YRS.				3-20-86 3 AM					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard				IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
10. CITY OR TOWN OF DEATH <i>Columbia MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>100. Co. Gen't Hosp.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sec.</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Singer Link</i>						
13a. STATE <i>Md.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Laurel</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>348 Old Line Ave. 21122</i>							
14. FATHER'S NAME FIRST <i>John</i>		MIDDLE <i>Olkowski</i>	LAST <i>Veronica</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Grabowski</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>139-28-5312</i>			17. INFORMANT <i>Frank Buono same as 13e</i>		ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic endometrial carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutely</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>3100 Columbia Rd.</i>			21f. LOCATION STREET <i>3100 Columbia Rd.</i>			CITY OR TOWN <i>Baltimore</i>		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>3/19/86</i> to <i>3/20/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>3/20/86</i>			
22b. SIGNATURE <i>Alan C. Stahl, MD</i>		22d. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alan C. Stahl, MD</i>		22f. ADDRESS <i>Columbia Medical Plaza</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/22/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE MEMOPK			23d. LOCATION CITY <i>Baltimore</i>		COUNTY	STATE <i>Balto. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>FLECK F.H. INC.</i>		ADDRESS <i>1601 Sandy Spring Rd. Laurel, MD.</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 21 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julie Duerden-Pendle</i>								

25010-00

AMERICAN  
CIVIL LIBERTIES  
UNION

HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate

**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completed in full, it should be attached to the burial-travel parent. Then please remove carbon copies. Pages 1 and 2 should be sent with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 6 1 0 8 6 6 2

00-01998

1 - FOR  
STATE  
REGISTRAR

M-A-00-C

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR 450 A.M.		
mary Ann Coffelt						3 29 86						
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Female	White	2 20 21			65 YRS							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
Columbia	U.S.A.											
CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Howard County General Hosp.						13a STREET ADDRESS / ZIP CODE 1354 Driver Rd. 21104						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
MD	13b COUNTY Howard	13c CITY OR TOWN Marietta						13e STREET ADDRESS / ZIP CODE 1354 Driver Rd. 21104				
14. FATHER'S NAME FIRST Tesse			MIDDLE	LAST Grimes	15. MOTHER'S MAIDEN NAME FIRST Jessie			MIDDLE F.	LAST Bosnell	ADDRESS		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b SOCIAL SECURITY NO 2826 6906			17. INFORMANT Graydon Coffelt Sr. Marietta, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Respiratory Obstructive Dz</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (o)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Antonio Fijo</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 3/29/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Antonio Fijo</u>		22e ADDRESS 9504 Old Georgetown Rd. Bethesda, Md.										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE 4-1-86		23c NAME OF CEMETERY OR CREMATORIAL Crestlawn Cemetery			23d. LOCATION MARIETTA CITY OR TOWN COUNTY STATE Howard Md					
24 FUNERAL DIRECTOR NAME <u>Harry W. Haight</u>		ADDRESS <u>Sykesville, Md.</u>		25a DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE <u>Jeanne Anderson Pendleton</u>					

12217-10



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80108063					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	WILLIAM	MIDDLE	L.	LAST	D'AUTRECHY	20. DATE OF DEATH	MONTH	3 DAY	20 YEAR	812b HOUR				
WILLIAM				L			D'AUTRECHY	03 20 86	0500H								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
MALE			WHITE			MONTH DAY YEAR October 23, 1937			48 48			MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.								
New Jersey			U.S.A.														
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD County General Hospital Program Manager			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Westinghouse			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Clarksville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7391 Hopkins Way 21029					
14. FATHER'S NAME FIRST Joseph			MIDDLE P.	LAST D'Autrechy Sr.		15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE Marie	LAST McBlain							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes Vietnam			17. INFORMANT Mrs. Lee R. D'Autrechy			ADDRESS Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS					
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC DYSRHYTHMIA												2 HRS					
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION												2 HRS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from MARCH 20, 19 86, to MARCH 20, 19 86, that (I) (we) lost saw the deceased alive on MARCH 20, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Linda J. Rever MD												DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS LINDA J. REVER MD. HOWARD County General Hos. Columbia, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/24/86			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION CITY OR TOWN Arlington			CITY STATE Virginia					
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witkze Funeral Homes P.A. 555 Twin Knolls Road, Columbia, MD.			25a. ADDRESS 21045			25b. DATE REC'D. BY REGISTRAR MAR 21 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Randall								

54110-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8608664

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR		
KEVIN					DUNNE	March 22, 1986			4:40 P.M.			
3 SEX		4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE	Sept. 6 1928			57	MONTHS	YEARS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY			MD.		
10 CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5411 THUNDERHILL ROAD			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STAGE HAND			12b KIND OF BUSINESS OR INDUSTRY BBC				
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 5411 THUNDERHILL RD 21045				
14. FATHER'S NAME FIRST JAMES		MIDDLE	LAST DUNNE	15. MOTHER'S MAIDEN NAME FIRST MARY			MIDDLE			LAST MOFAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE			17. INFORMANT ESTHER MacLAURIN			5411 THUNDERHILL RD. COLUMBIA, MD 21045				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gadenoacarcinoma of stomach - metastatic</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Anemia, Hepatic encephalopathy, malignant ascites</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>86</u> , to <u>March 22, 1986</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Jon Minfard</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3-24-86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jon K. Minfard MD</i>		22f. ADDRESS 10804 Hickory Ridge Rd, Columbia, MD 21044										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 25 MAR 86		23c. NAME OF CEMETERY OR CREMATORIAL GOOD SHEPHERD CEM.			23d. LOCATION CITY OR TOWN ELLIOTT CITY		COUNTY HOWARD	STATE MD.		
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 268 ELLIOTT CITY, MD 21043			25a. DATE REC'D. BY REGISTRAR MAR 26 1986		25b. REGISTRAR'S SIGNATURE <i>John Minfard</i>					

3711-00

200

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or torn, it may injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.
00-02357				86108005
1. DECEASED NAME (TYPE OR PRINT)	FIRST JOHN	MIDDLE OAKLEY	LAST FEARSON	2d DATE OF DEATH MONTH 3 31 YEARS 86 2d. HOUR 9:30PM
2. SEX MALE	3. RACE WHITE	4. DATE OF BIRTH MONTH 01 DAY 20 YEAR 16	5. AGE (IN YEARS LAST BIRTHDAY) 70	IF UNDER 1 YEAR 70 MONTHS DAYS HOURS MIN
6. IF MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	10. CITY OR TOWN OF DEATH COLUMBIA		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS HOWARD COUNTY GENERAL HOSPITAL				
13a STATE Maryland	13b COUNTY Howard	13c CITY OR TOWN Ellicott City	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 3101 Hayfield Drive 21043
14. FATHER'S NAME FIRST John	MIDDLE O.	LAST Pearson	15. MOTHER'S MAIDEN NAME FIRST Sue	MIDDLE E.
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. WW II	17. INFORMANT Mabel F. Pearson	ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE				
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE 6 WEEKS				
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS 6 WEEKS				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Polymyositis				
19a. DATE OF OPERATION 1-16-86 2-18-86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RIGHT UPPER LOBECTOMY - LUNG CARCINOMA TRACHEOSTOMY - RESPIRATORY FAILURE			20a. AUTOPSY? NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) 19	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) JAN 6	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (s) (this hospital) attended the deceased from <u>MARCH 31</u> , 19 <u>86</u> , to <u>MARCH 31</u> , 19 <u>86</u> , that (s) (we) lost saw the deceased alive on <u>MARCH 31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.				
22b. SIGNATURE DEGREE				
Linda J. Rever M.D.				
22c. DATE SIGNED 3-31-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Linda J. Rever M.D.				
22e. ADDRESS HOWARD COUNTY General Hosp. COLUMBIA, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/3/86	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCATION CITY OR TOWN Baltimore	STATE Maryland
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228	25a. DATE REC'D. BY REGISTRAR APR 02 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton

1783 b-60



TOOK A LOOK AT

THESE COMMENTS

21-937

-12-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon imparts. Page 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR						2a DATE OF DEATH			REG. NO. 8666610		
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			MONTH DAY YEAR			MONTH DAY YEAR		
DORA BLUEFELD GOLDBERG						Sep. 15, 1911			March 24, 1986		
3. SEX Female			4. RACE White			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
						MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt., Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.		
10 CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Bethesda			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME Charles			15. MOTHER'S MAIDEN NAME Bessie			13e STREET ADDRESS / ZIP CODE (20814) 5225 Pooks Hill Road, #1001S.			LAST Bisker		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 220-76-0643			17 INFORMANT Louis Goldberg; Son; 16905 Old Colony Way;			ADDRESS Rockville, Md. 20853		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lung congestion and pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3-24</u> , 19 <u>86</u> , to <u>3-24</u> , 19 <u>86</u> , that (we) lost sow the deceased alive on <u>3-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>R.S. Goodwin</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/24/1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. GOODWIN, M.D.			22e ADDRESS 9650 Santiago Rd., Columbia, Md.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 3/25/1986			23c NAME OF CEMETERY OR CREMATORIAL King David Mem. Gdn. Falls Church, Virginia			23d LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME Rockville, Md.						25a DATE REC'D. BY REGISTRAR MAR 27 1986			25b. REGISTRAR'S SIGNATURE <i>Julia L. Johnson-RP</i>		
Danzansky-Goldberg Chapels; 1170 Rockyville Pike											

FOR MAILING BIRTH CARD

111  
Ave. Apt. 4

Maryland ZIP CODE 21215

ED (Specify only highest grade completed)

1) College (1-4 or 5 +)

071160

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608667

1 -  
FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR						
BERTHA				B.		GORSUCH	3	7	1986	5:00 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Female		White		MONTH 9 DAY 20 YEAR 1899			86 YRS.			Virginia			Howard County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY									
Columbia		Lorien Nursing Home			Homemaker			Own Home									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Catonsville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 606 North Bend Rd. Catonsville Md. 21228							
14. FATHER'S NAME FIRST Robert		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Rebecca													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO			17. INFORMANT			ADDRESS									
		-----			Betty North 205 E. Joppa Rd. Unit 1101			Towson, Md. 21204									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Huntington's Chorea												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years					
DUE TO, OR AS A CONSEQUENCE OF (b) Phrenomimic												2 wks					
DUE TO, OR AS A CONSEQUENCE OF (c) Viral Infection												2 wks					
DUE TO, OR AS A CONSEQUENCE OF (c) Nutritional Anemia												1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		1986			19			3/7/86									
above, (I) <input type="checkbox"/> did not view the body after death.																	
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/10/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Dr. W. E. McGrath			22e. ADDRESS			1303 Frederick Rd. Catonsville, Md. 21228									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE				
Burial		3/11/86		Baltimore National Cemetery			Baltimore			Maryland							
24. FUNERAL DIRECTOR NAME		1630 Edmondson Ave. Catonsville, Md. 21228 Leroy M. & Russell C. Witzke Funeral Home			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
					MAR 10 1986												

601170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	1156	08068					
										REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)							2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			John I. Green							03	25	86	3:05 PM				
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR			# UNDER 24 HRS				
MALE			White	MONTH	DAY	YEAR	56	56	YRS.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			U.S.A.						Howard Co.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia			Howard Co. General Hosp.							Mechanic			Auto/Truck				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland			Baltimore	Catonsville						2107 Oak Lodge Road 21228							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
			Edgar	Raymond	Green	Annie M.									Lindsay		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No			213-26-2201			Joyce Green			Same as # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia																	
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Stomach-metastatic 10 months																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).																	
Chronic anemia, Cutaneous metastases,																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 1985, to March 25, 1986, that (I) (we) last saw the deceased alive on March 25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3-25-86							
22b. SIGNATURE John Minford MD										DEGREE	ATTENDING PHYSICIAN	X MEDICAL DIRECTOR	STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John K. Minford										22e. ADDRESS	10806 Hickory Ridge Rd, Columbia MD 21046						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY					
Burial			3/28/86			Meadowridge Memorial			Ph. Dorsey			MD.					
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P. 1630 Edmondson Avenue, Catonsville, MD. 21228										25a. DATE REC'D. BY REGISTRAR	MAR 27 1986				25b. REGISTRAR'S SIGNATURE		

50810-00

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10/12/2019

00-02265

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 08669

REG. NO.

1 - STATE  
REGISTRAR

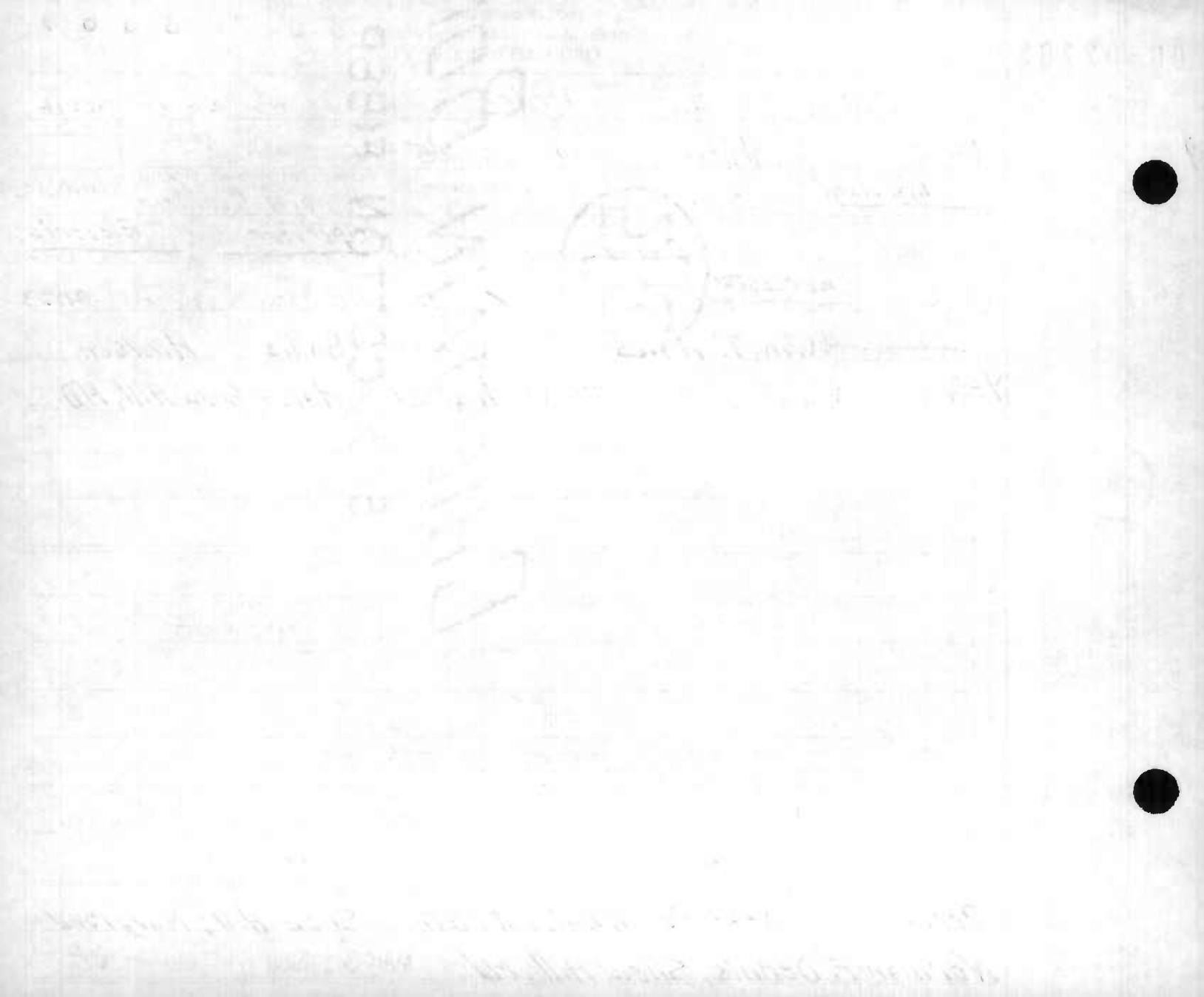
1 DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
				John	A.	Hales	03	26	86	0859AM	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7b HOUR	
Male		White		MONTH	DAY	YEAR	80	IF UNDER 1 YEAR	IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			YRS	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OR PRINT)			12b KIND OF BUSINESS OR INDUSTRY (TYPE OR PRINT)			13c STREET ADDRESS / ZIP CODE	
Columbia		Howard County General Hospital		Operator Unknown			Unknown			210 Coulburne Rd. 21863	
14 STATE		15 CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			LAST	
MD.		Howard		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			ADDRESS			Hudson	
16 FATHER'S NAME FIRST		MIDDLE		15 MOTHER'S MAIDEN NAME FIRST			ADDRESS			LAST	
Unknown		Wm. T. Hales		Unknown Sallie			ADDRESS			Hudson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO UNKNOWN		16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Bankroll		212-05-4160		Mildred S. Hales, Snow Hill, MD.			ADDRESS			Approximate interval between onset and death	
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>NSCUD</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) (not) view the body after death.											
22b. SIGNATURE <u>Levan Kuck</u>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/26/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Levan Kuck</u>		22e. ADDRESS <u>HOWARD COGBN HOSP.</u>									
23a BURIAL, CREMATION, REMOVAL (COPY)		23b DATE 3-29-86		23c NAME OF CEMETERY OR CREMATORIAL Whitcoat Meth.		23d LOCATION CITY OR TOWN Snow Hill, Maryland		23e. DATE REC'D. BY REGISTRAR MAR 31 1986			
24 FUNERAL DIRECTOR NAME <u>Norman F. Dennis, Snow Hill, Md.</u>		ADDRESS				25b REGISTRAR'S SIGNATURE <u>Handwritten Signature</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

00-01836

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please attach pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, have medicolegal examined.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608670					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HELEN			M.		KATSS			3 26 86			9:00		M	9:00 AM	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			WHITE		MONTH DAY YEAR			77			MONTHS	DAYS	HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.					Howard							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia			Howard County General Hosp					Homemaker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland			A.A.		Glen Burnie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9 Magnolia Avenue 21061				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Mack					
William			Buppert		Marie										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			216-32-2221		Fred V. Kaiss			9 Magnolia Ave. 21061							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CAR DIAC ARREST					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										SEPSIS / ARDS					
DUE TO, OR AS A CONSEQUENCE OF (b)															
(c)										ACUTE RENAL FAILURE					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										ASCD, PARKINSONS D.					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
			P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/26/1986, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										3/26/1986 to 3/26/1986, that (I) (we) lost					
22b. SIGNATURE										DEGREE	22c. DATE SIGNED				
<i>G.W. RUFER</i>										MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	3/26/1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. LOCATION CITY OR TOWN			COUNTY	STATE					
G.W. RUFER			10840 LITTLE PATUXENT PKWY COLUMBIA, MD. 21044												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR	23f. REGISTRAR'S SIGNATURE		
Burial			3/28/86			Lorraine Park Cemetery			Woodlawn			Baltimore	Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			21229			MAR 27 1986			<i>India Davidson Pendleton</i>			
Hubbard Funeral Home, Inc.			4107 Wilkens Ave.												

261

22 July 1978 - 10:00 a.m.

Wetland area, 200' from stream

Soil type: ~~soil~~ sand, loam, mud

Vegetation: grass, weeds, shrubs, trees

Water level: 0.5' above ground level

Temperature: 72°F

Humidity: 85%

Wind speed: 0 mph

Cloud cover: 0%

Sun position: NNE

Other notes: No birds seen or heard

00-01084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be retained within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 8 6 0 8 6 7 1												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Venkataraman Krishnamoorthy						March 14, 1986						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS		
Male		White		May 3, 1936			49			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
India		U.S.A.					Howard County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Columbia		5840 Alderleaf Place 21045			Scientist Tracor Hydronautics							
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21045 5840 Alderleaf Place		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Krishnaswamy Venkataraman		Alamemlu										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		112 42 4266		M's Mercedes Krishnamoorthy			5840 Alderleaf P			20 months		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bile duct obstruction, Chronic anemia, Ureteral obstruction												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1984, to March 19, 1986, that (I) (we) last saw the deceased alive on March 19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Jan K. Minford		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3-15-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jan K. Minford		22e. ADDRESS 10806 Hickory Ridge Rd, Columbia, MD 21044										
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE March 18 '86		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn			23d. LOCATION CITY OR TOWN Howard County Maryland					
24. FUNERAL DIRECTOR NAME Harry H Witzke & Family Funeral Home ADDRESS ADDRESS Inc. 4112 Old Columbia Pike Ellicott City					25a. DATE REC'D. BY REGISTRAR MAR 21 1986			25b. REGISTRAR'S SIGNATURE John L. Witzke				

Set , 10 days ago - government - 1000

Set , 10 days ago - 1000

Set , 10 days ago - 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial funeral parlor. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked on item 18, show any injury or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 6 0 8 6 7 2					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
KING B. LEE						3 16 86			2:55 P.M.						
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.						
MALE			oriental			6 8 0 8 4			61						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co.						
Md.			U.S.A.												
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. Gen Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed			12b. KIND OF BUSINESS OR INDUSTRY Food Shop.						
13a. STATE MD			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2531 North Farm Rd. 21043			
14. FATHER'S NAME Sing			MIDDLE Tong			15. MOTHER'S MAIDEN NAME Lee			16. SOCIAL SECURITY NO. 218-224-423			17. INFORMANT M's Marie Lee 2531 North Farm Rd. 21043			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> NO			18b. SOCIAL SECURITY NO. <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Loesin - Respiro</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Shock</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>End Stage Liver &amp; Renal Failure</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/21/86					
22b. SIGNATURE <i>J. Goss</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. Goss			22d. ADDRESS Columbia Medical Center Site 210												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-20-86			23c. NAME OF CEMETERY OR CREMATORIAL Corraine			23d. LOCATION CITY OR TOWN			24. FUNERAL DIRECTOR NAME Harry H. Witzke & Family Fun. Ho., Ellicott City		25a. COUNTY Baltimore Md.	
												ADDRESS 4112 Columbia Md.		25b. DATE REC'D. BY REGISTRAR MAR 21 1986	
														25c. REGISTRAR'S SIGNATURE <i>John Davidson-Pandell</i>	



00-01973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be delivered to the funeral home or to the burial authority. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 6 7 3			
										REG. NO.			
1. FOR STATE REGISTRAR			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			LEWIS			03-28-86						253 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
FEMALE			CAUCASIAN			MONTH DAY YEAR			84			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
COLORADO			USA						HOWARD COUNTY MD.			YRS.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
COLUMBIA			HOWARD COUNTY General Hospital			HOUSEWIFE			AT HOME				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
MARYLAND			HOWARD			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5436 HARPERS FARM RD. #21044				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST JOSEPH			FIRST MIDDLE LAST LENA										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			278-32-8268			MELVYN LEWIS			5656 THICKET LA. COLUMBIA, MD 21044				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) PNEUMONIA										DAYS			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
MULTI-INFARCT DEMENTIA													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the deceased) attended the deceased from 3.8.86, 19_____, to 3.28.86, 19_____, that (I) (we) lost saw the deceased alive on 3.28.86, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.										22c. DATE SIGNED 3.28.86			
22b. DEGREE MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS T.A. DADISMAN JR MD										22f. ADDRESS 2101 NORTH DR., COLUMBIA MD 21045			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 30, 1986			23c. NAME OF CEMETERY OR CREMATORIAL BETH TFILOH			23d. LOCATION BALTIMORE				
									COUNTY MARYLAND				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215										25a. DATE REC'D. BY REGISTRAR APR 01 1986			
										25b. REGISTRAR'S SIGNATURE John Davidson - Pendleton			

~~81810-00~~

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THE COUNCIL OF THE SOCIETY FOR THE ADVANCEMENT OF SCIENCE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FULL NAME OF DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 4 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08674						
REG. NO.																		
DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR			
James			J.			Lewis						<input checked="" type="checkbox"/> 3/13/1986			M 24 HOUR MONTH DAY YEAR			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 51			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR MONTH DAY YEAR	
Male		W		09 04 1934			51 yrs.							3/13/1986			M 24 HOUR MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Howard County,									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
West Friendship			Trailer #2, Harliss Farm			Farmhand			Dairy									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Md.			Howard		West Friendship		Trailer #2, Harliss Farm 21799											
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
FIRST DAVID MIDDLE J LAST LEWIS			FIRST ELIA MIDDLE LOUISE LAST Asbury															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
			215-66-9161 Evelyn Ruth Nipper						Box 224 West Friendship, MD 21799									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Chronic Obstructive Pulmonary Disease and Acute Alcoholism																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?												
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion						
ACTUAL SIGNATURE												TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D.			ADDRESS			111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE			
Burial			11 March 86			St. John's Cemetery			Ellicott City			Howard			MD			
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
SLACK FUNERAL HOME			Box 263			1986												

COLLECTOR'S

00-00730

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608675

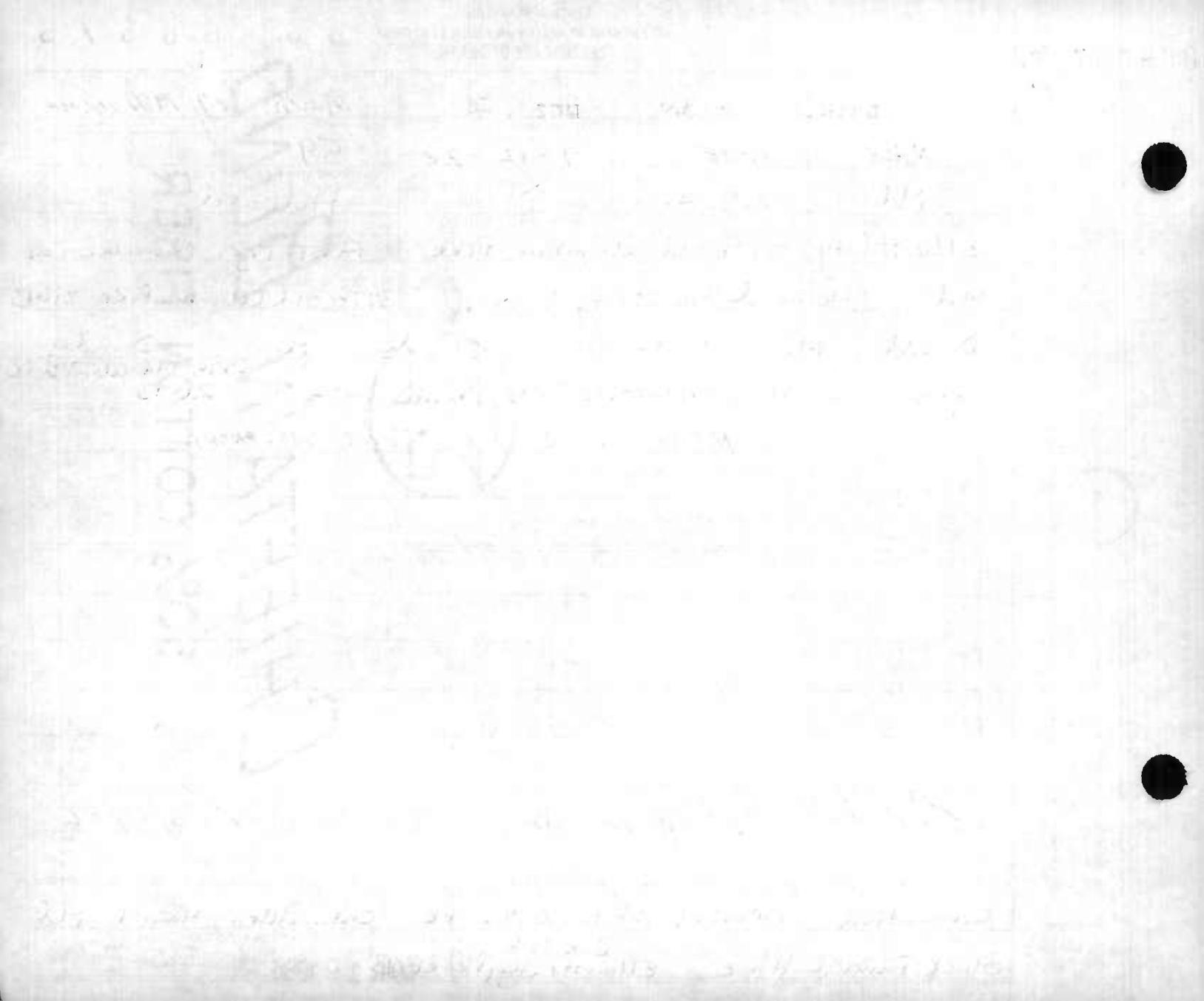
REG. NO.

1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR						
I. DECEASED NAME FIRST MIDDLE LAST			3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
<b>DONALD MILTON LUTZ, JR.</b>									'7-12-86			59 YRS			
7d. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.						
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3978 Old Columbia Pike			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Mgr.			12b. KIND OF BUSINESS OR INDUSTRY Merchandise Corp.						
13a. STATE Md.			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3978 Old Columbia Pike 21043			
14. FATHER'S NAME FIRST MIDDLE LAST Donald M. Lutz, Sr.			15. MOTHER'S MAIDEN NAME Gertrude M. Dandy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 219-22-6135			17. INFORMANT Ms. Phyllis Lutz			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC MALIGNANT MELANOMA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												27. DATE SIGNED 3/18/86			
22b. SIGNATURE Michael E. Beloyan, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cremation			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 19 Mar. 86			23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.			23d. LOCATION CITY OR TOWN Catonsville			COUNTY Harford		STATE Md.	
24. FUNERAL DIRECTOR NAME Slack Funeral Home			ADDRESS Box 268 Ellicott City, Md. 21043			25a. DATE REC'D. BY REGISTRAR MAR 19 1986			25b. REGISTRAR'S SIGNATURE John Davidson Pendleton						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to carbon paper. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 18 shows any injury, or other terminal disease, medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 86-108676				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR MARC 12, 1986									2b. HOUR 11 <sup>35</sup> A.M.				
1. DECEASED NAME FIRST MARY JANE MIDDLE JANE LAST MARPLE Mary Jane Marple			5. DATE OF BIRTH MONTH 5 DAY 11 YEAR 00			6. AGE (IN YEARS LAST BIRTHDAY) 85			IF UNDER 1 YEAR MONTHS 0 DAYS			IF UNDER 24 HRS HOURS 0 MIN.				
3. SEX F			4. RACE C			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County			MD.	
10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Ext. Care Facility			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Md.			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 711 Maiden Choice Lane			71228				
FATHER'S NAME UNKNOWN			LAST Haxnive			15. MOTHER'S MAIDEN NAME Mindra			MIDDLE Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 164-16-5831			17. INFORMANT Dr. T. McCabe, BV - Bon Secours ECF			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable cerebrovascular accident												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) chronic atrial fibrillation																
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.																
DUE TO, OR AS A CONSEQUENCE OF (c) ischaemic cardiac disease																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION MA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec 1985 to 3/12 1986, that (II) (we) last saw the deceased alive on 3/10 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) see the body after death.																
22b. SIGNATURE H. J. MAURER			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/10/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURER			22e. ADDRESS 11085 LITTLE PAT PKWY COLUMBIA MD 21043													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-13-86			23c. NAME OF CEMETERY OR CREMATORIAL Security Process			23d. LOCATION CITY OR TOWN Catonsville, Balto. MD			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Cremaion Society of MD, Baltimore MD			ADDRESS 21228			25a. DATE REC'D. BY REGISTRAR MAR 13 1986			25b. REGISTRAR'S SIGNATURE J. K. Kistner Pendell							
DHMH - 16 60M 7/84 (VRA 15, 4)																

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00-02478		Film G614 item 17 FOR STATE 4/25/86 rja REGISTRAR	STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						86	08671			
									REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
IRENE L. MONTGOMERY								3-31-86				140 P.M.	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
F		W		MONTH DAY YEAR 1 23 98		88		MONTHS DAYS		HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.					
S.DAK.		U.S.A.				HOWARD							
11. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
COLUMBIA LORIEN NURSING HOME								R.N.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD		Montgomery		ROCKVILLE		YES <input type="checkbox"/> NO <input type="checkbox"/>		6306 HUNTOVER LN.					
14. FATHER'S NAME FIRST		LAST		15. MOTHER'S MAIDEN NAME MIDDLE		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Melvin C Mortisen				Margaret C Reynolds		507-52-4527		Olsen		Robert Craig Olsen 6306 HuntOver La 20852			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
NO		507-52-4527		3 days									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <u>CARDIORRESPIRATORY ARREST</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Exacerbation of Chronic Obstructive Pulmonary Disease</u>											
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>- Chronic Pulmonary Disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-27-84 to 3-31-86, that (I) (we) last saw the deceased alive on 3-18-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Krishna P. Kumar</u>		DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-31-86.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KRISHNA P. KUMAR</u>		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 1, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Westview		23d. LOCATION CITY OR TOWN Catonsville		COUNTY Balto.		STATE Maryland			
24. FUNERAL DIRECTOR Harry H Witzke & Family Funeral Home Inc 4112 Old Columbia Pike Ellicott City		25a. DATE REC'D. BY REGISTRAR APR 03 1986		25b. REGISTRAR'S SIGNATURE <u>Pandit</u>									
NAME ADDRESS													

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 6 7 8				
										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS	UNDER 24 HRS HOURS MIN.				
WILLIAM ALTON MOORE						March 4, 1986				7:00 AM				
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. ADDRESS				
Male			White		September 1, 1904		81			YRS.				
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Howard County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Columbia			10213 Wesleigh Drive							Retired			- Calvert Distillery	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Howard		Columbia					10213 Wesleigh Drive 21046				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST				
Alfred					Moore	Julia			A.	Iager				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			215-16-2991			Mrs. Shirley Rogers			Same as # 13			5min		
18. CAUSE OF DEATH (Enter only one cause per line for item 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> ~10 years														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Lymphoma</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) <u>(the physician)</u> attended the deceased from <u>9/19</u> , 19 <u>85</u> , to <u>3/4</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>86</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.														
22b. SIGNATURE <u>Jabs B. Lodish</u>			22c. DEGREE <u>M.D.</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>3/5/86</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			22g. ADDRESS								
Lodish M.D.			2901 Sandy Spring Road, Olney, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/7/86			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul Lutheran			23d. LOCATION CITY OR TOWN Fulton			STATE Maryland		
24. FUNERAL DIRECTOR Letoya M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, MD. 21045						25a. DATE REC'D. BY REGISTRAR MAR 7 1986			25b. REGISTRAR'S SIGNATURE <u>John J. Connelly</u>					

LOGON

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked Yes, Item 22 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3608579			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
HENRY			A.		MULLEN	03 06 86						12 <sup>55</sup> PM			
1. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		August 8, 1904			81			YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD					
New York		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Columbia		Howard County General Hospital			Retired			Accountant							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Maryland		Howard		Columbia			YES <input type="checkbox"/> NO <input type="checkbox"/>			5604 Freshaire Lane 21044					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Francis Mullen		Margaret Monority													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> NO OR UNKNOWN		16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			21044				
<input checked="" type="checkbox"/> YES, GIVE WAR OR DATES:		115 03 6428A			Charles Mullen			5604 Freshaire La.			Columbia				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)															
DUE TO, OR AS A CONSEQUENCE OF (c) Nonspecific Pneumonia															
DUE TO, OR AS A CONSEQUENCE OF (c) Unknown															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hypotension															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					<input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b. DATE SIGNED 4/16/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
MAURER		MEDICAL ARTS BLDG COLUMBIA MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN		COUNTY			
Burial		April 9 '86		Crestlawn			Howard Maryland								
24. FUNERAL DIRECTOR NAME Inc. 4112 Columbia Pike Ellicott City		ADDITIONAL NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
					APR 10 1986			Julia Davidson-Randall							

TG 120-02



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit. Then please remove carbon paper. Please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, air removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE M. O'CONNOR	LAST	2d DATE OF DEATH March 10, 1986	MONTH	DAY	YEAR	2d HOUR 9:20 AM
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH March DAY 26, YEAR 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) Howard County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst		12b. KIND OF BUSINESS OR INDUSTRY Engineering			
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9085 A Town & Country Blvd. 21043	
14. FATHER'S NAME Edward O'Connor MIDDLE			LAST		15. MOTHER'S MAIDEN NAME Nellie Murray		MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		21044	
					Mrs Perry Moore		6128 Llanfair Dr. Columbia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Hepatorenal syndrome		DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					DUE TO, OR AS A CONSEQUENCE OF (c) Chronic ethanolism				21 days. years.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hemorrhage from Chronic Duodenal ulcer										
19a. DATE OF OPERATION 2/8/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <u>March 10</u> , 19 <u>86</u> , to <u>March 10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>March 10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not) (I) did not view the body after death.										
22b. SIGNATURE WILLIAM PARNES			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-10-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM PARNES			22e. ADDRESS 11085 Little Patuxent Pkwy Columbia MD 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 13'86		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn		23d. LOCATION CITY OR TOWN		COUNTY Howard STATE Maryland	
24. FUNERAL DIRECTOR Harry H Witzke & Family Funeral Home NAME <sup>OWNER</sup> Inc 4112 columbia Rd Ellicott City			25a. DATE REC'D. BY REGISTRAR MAR 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson Pendleton					

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070033

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 08681

REG. NO.

1 - STATE  
REGISTRAR

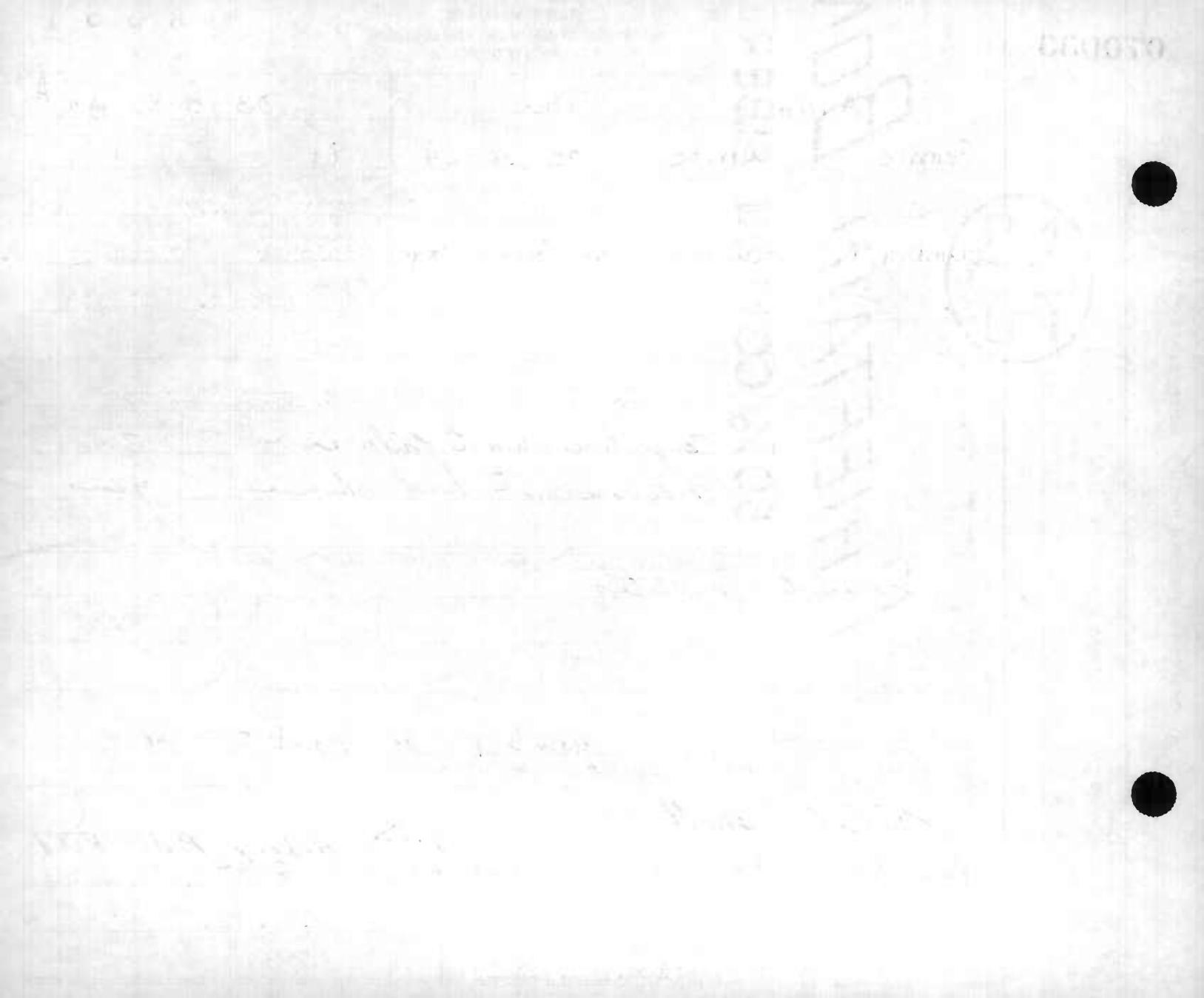
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>ANNA</b>	MIDDLE <b>Pace</b>	LAST	2d. DATE OF DEATH MONTH <b>03 - 5 - 86</b>	DAY	YEAR	2b. HOUR 10:30 A.M.		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>05 - 28 - 04</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>			10. CITY OR TOWN OF DEATH <b>Columbia, MD</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Howard County General Hosp</b>		
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13. STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>7006 Park Dr. 21234</b>	12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Finisher</b>	12c. KIND OF BUSINESS OR INDUSTRY <b>Clothing Bus.</b>					
14. FATHER'S NAME FIRST <b>Carlo Madonna</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Lucia Ciampini</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>215-18-7303 Gloria Trenner, same address</b>									
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>					
Conditions, if any, which gave rise to immediate cause 18, stating the underlying cause last (b) <b>Arteriole casts heart disease</b>						<b>years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Scabates mellitus</b>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1986</b> to <b>March 5, 1986</b> , that (I) (we) last saw the deceased alive on <b>March 5, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <b>Richard W. Smith, M.D.</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard W. Smith, M.D.</b>	22e. ADDRESS <b>10802 Hickory Ridge Road Columbia, Md. 21044</b>	22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/8/86</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer</b>	23d. LOCATION CITY OR TOWN <b>Balto., Md.</b>	COUNTY	STATE						
24. FUNERAL ORGANIZATION NAME <b>Schiminek Funeral Home, Inc.</b>	ADDRESS <b>9705 Belair Rd., Balt., Md. 21212</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1986</b>	25b. REGISTRAR'S SIGNATURE <b>J. Anderson-Pondale</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediately report it to the medical examiner.

660030



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the hospital or attending physician, it should be deposited for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 will be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X" shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 6 8 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Robert G. Paine						March 12, 1986				2:15AM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Jan 1, 1927		59		MONTHS		DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		YRS.		
Illinois		U.S.A.										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN PART 1, GIVE STREET ADDRESS)		Howard County General Hospital		12a USUAL OCCUPATION (TYPE OR PRINT OR LIST OF WORKING LIFE)		Retired		12b. KIND OF BUSINESS OR INDUSTRY		
Columbia												
13a STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Howard		Ellicott City		YES <input type="checkbox"/> NO <input type="checkbox"/>		3244A Normandy Woods Drive		2104		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Unknown			Paine		Bessie Caltrider							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c		17 INFORMANT		ADDRESS				
Yes		WW II		217 20 6908		Mrs Joan Paine		3244 A Normandy Woods Drive		21043		
18 CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Accident - Post. M/</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sedatives mild</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anesthesia. evd</i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) <i>attending physician</i> deceased from <i>1-0-54</i> 19 to <i>3/12/86</i> 19, that (I) (we) last saw the deceased alive on <i>3/9/86</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>George Avog</i>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED <i>3/12/86</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 14, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Westview		23d. LOCATION CITY OR TOWN Catonsville		COUNTY Balto., Md.		STATE		
24. FUNERAL DIRECTOR NAME Inc. 4112 Old Columbia Pike Ellicott City						25a. DATE REC'D. BY REGISTRAR MAR 14 1986		25b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>				



00-02748

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 08683

1- STATE REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**MEDICAL CERTIFICATION**

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR M		
FRANKLIN			PATTISON			<input checked="" type="checkbox"/> 3	27	19	86	12:45 PM		
2c. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR M		
Male	White	June 10, 1940	45 yrs.	MONTHS	DAYS	HOURS	MIN	3	28	19 86	12:45 PM	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		USA					Howard County			grocery store		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. STREET ADDRESS			MD.		
Laurel		woods-off of 7800 blk. Murray Hill Rd.			warehouseman		1149 12 th Street 20707					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Prince George		Kt Laurel				1149 12 th Street 20707				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Thomas		Foley	Pattison	Mildred		Waters						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
no		220 36 6057			Janet Pattison same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Perforating gunshot wound of head (handgun)												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? Head Only <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3-27- 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY			
		woods off of			7800 blk. Murray Hill Rd., Head Only		Howard		STATE MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE 												
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												
ADDRESS 111 Penn St., Balto., MD 21201												
23a. BURIAL, CREMATION, REMOVAL		23b. DATE March 31, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		
Burial						Baltimore, Md						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Donaldson Funeral Home, Laurel, Md												

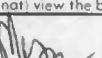
DATA  
RECORDS  
NOTEBOOK

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and **certified** **13** in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, Pages 14-17 should be left attached to the back of this certificate for the **Health and Mental Hygiene** to review and sign. **18** hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
JANE A. PELLEGRINI						MARCH 23 1986				10 AM	
3 SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE	JAN. 20 1924			62 yrs		MONTHS	DAYS	HOURS	MIN.
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY				
MD.		U.S.A.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
ELLIOTT CITY		9862 HELMWOOD COURT			SALES LADY		DEPT. STORE				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE MD.		13b COUNTY <input checked="" type="checkbox"/>		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4623 FURLEY AVE. 21206			
FATHER'S NAME FIRST WALTER		MIDDLE		LAST STEFANOWICZ		13f MOTHER'S MAIDEN NAME PETRONELLA		LAST GRINKEVICH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-20-8384		17 INFORMANT JANE NAVARRIA-DGHTR-		ADDRESS 4618 MARY AVE. 21206					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						19 86, to Jan 19 86, that (I) (we) last					
22b SIGNATURE 						DEGREE					
22c ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						DATE SIGNED					
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. MYO THANT						22e ADDRESS FRANKLIN SQUARE MED. ARTS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE 3/26/86		23c NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		23d LOCATION CITY OR TOWN Baltimore		COUNTY		STATE Md.	
24 FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME, INC. ADDRESS 3331 Brehms Lane, Balto. Md. 21213						25a DATE REC'D. BY REGISTRAR MAR 26 1986		25b REGISTRAR'S SIGNATURE 			

00813-00

0-02163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Please file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8608685

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>DAISY B PERRIE</i>			<i>B</i>		<i>PERRIE</i>	<i>3</i>	<i>3</i>	<i>30</i>	<i>86</i>	<i>6 10 PM</i>	
3. SEX		4 RACE	5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		# UNDER 24 HRS.		
<i>FEMALE</i>		<i>CAUCASIAN</i>	MONTH	DAY	YEAR	<i>73</i>	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>MARYLAND</i>		<i>USA</i>					<i>HOWARD County</i>				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
<i>COLUMBIA</i>		<i>HOWARD COUNTY GENERAL HOSP.</i>			<i>COMPANION</i>			<i>DOMESTIC</i>			
13a STATE		13b COUNTY	13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE				
<i>MARYLAND</i>		<i>HOWARD</i>	<i>ELLIOTT CITY</i>				<i>3621 CHATHAM RD. 21043</i>				
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		LAST				
<i>THOMAS</i>				<i>SARAH</i>			<i>WINDSOR</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
<i>NO</i>		<i>212-64-7871</i>			<i>EARLINE SHARBAUGH</i>		<i>3621 CHATHAM RD. ELLIOTT CITY, MD. 21043</i>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 days -</i>											
COPD RADIO PULMONAR. RADS PULMONARY EMBOLISM UNKWN											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>CARCINOMA OF BLADDER, STOMACH ULCER WITH HEMORRHAGE.</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
<i>3/25/86</i>		<i>BLEEDING DUODENAL ULCER</i>			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>3/25/86</i> 19 <i>19</i> , to <i>3/30/86</i> 19 <i>19</i> , that (I) (we) lost saw the deceased alive on <i>3/30/86</i> 19 <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
<i>RICHARD A. CURRIE M.D.</i>								<i>3/30/86</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
<i>RICHARD A. CURRIE</i>		<i>TWO KNOLL NORTH COLUMBIA MD 21045.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		23e COUNTY			STATE
<i>Burial</i>		<i>2 APRIL 86</i>		<i>ST. JOHNS Cemetery</i>		<i>ELLIOTT CITY Howard</i>		<i>MD</i>			
24 FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>SLACK Funeral Home</i>		<i>Box 263 ELLIOTT CITY, MD 21043</i>			<i>APR 02 1986</i>						

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(b)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

00-01838

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 6 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
PAULINE L POEHLMAN						3	26	86		11 50 p.m.	
J. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE		CAUCASIN		MONTH	DAY	YEAR	66	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Virginia		USA				HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
COLUMBIA, MD		HOWARD COUNTY GEN. HOSP								RETIRED	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD		AA		HANOVER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7303 FOREST AVE 21076		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		
				Crawford		Emma			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		400 18 6639		Norman D. Poehlman, Sr. Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) END STAGE RESPIRATORY FAILURE											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-26-1986 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. James		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED March 27, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMESH SABAPATHI		22e. ADDRESS Howard County General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 30, 86		23c. NAME OF CEMETERY OR CREMATORIAL Security Process, Ind.			23d. LOCATION CITY OR TOWN Catonsville		COUNTY Balto. MD		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR MAR 31 1986									
		25b. REGISTRAR'S SIGNATURE James S. Kirkley, Glen Burnie, MD									

be assured within 24 hours after death. Page 4 may be

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Certification section must be completed.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 6 8 /				
1 - FOR STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR					
<i>Suzanna M. REICHARDT</i>						<i>MARCH 28, 1986</i>			M					
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<i>FEMALE</i>		<i>WHITE</i>		<i>MARCH 3 1908</i>			<i>78</i>							
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>MARYLAND</i>		<i>U.S.A.</i>					<i>Howard County</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<i>ELLIOTT CITY</i>		<i>Bon Secours Ext. Care Facility</i>								<i>Homemaker</i>		<i>Domestic</i>		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
<i>MD.</i>		<i>Howard</i>		<i>Elliot City</i>					<i>10201 MARLEWOOD DR. 21043</i>					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
<i>William</i>			<i>McCoy</i>	<i>Susanna Armstrong</i>			<i>216-72-2818</i>		<i>Peter P. Reichardt</i> <i>Elliot City, MD 21043</i>					
18. CAUSE OF DEATH Enter only one cause per line for 1(a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>Cadre - almoscuring arrest</i>										20 minutes				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>multiple CVA's</i>										2 weeks				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>3/5</i> 19 <i>86</i> to <i>3/28/86</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/5</i> 19 <i>86</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not examine the body after death.														
22b. SIGNATURE <i>C.E. Sheddaw M.D.</i>										DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>3/28/86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
<i>C.E. Sheddaw M.D.</i>			<i>11055 Little Patuxent Pkwy 21044</i>											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL LOCATION			23d. LOCATION CITY OR TOWN						
<i>Burial</i>			<i>APRIL 86</i>		<i>Holmeswood Mem. Ar.</i>			<i>Baltimore Howard MD</i>						
24. FUNERAL DIRECTOR NAME			ADDRESS							25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<i>STARK FUNERAL HOME</i>			<i>Bldg 2002 Elliot City MD 21043</i>							<i>APR 02 1986</i>		<i>John J. Murphy</i>		

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page 3  
original direct  
copy 2 should be filed within 72 hours after death

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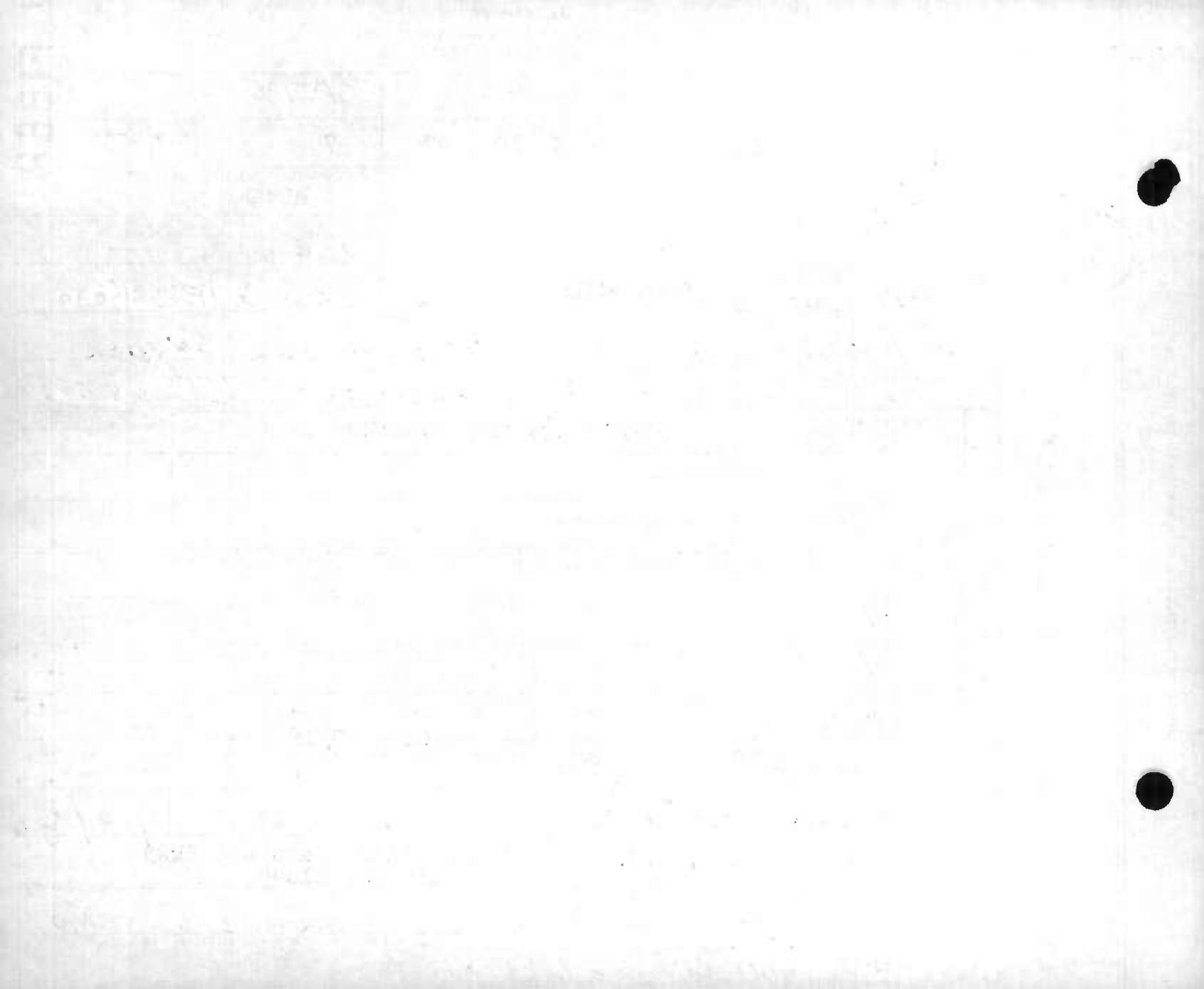
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 00-01081											9 8 6 8 8 8	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>JAMES</b>	MIDDLE RETTGER	LAST	2a DATE OF DEATH MONTH <b>3</b> DAY <b>18</b> YEAR <b>1986</b>	MONTH	DAY	YEAR	2b. HOUR <b>1 PM</b>		
3. SEX <b>Male</b>			RACE - <b>White</b>	S. DATE OF BIRTH MONTH <b>5</b> DAY <b>19</b> YEAR <b>07</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Conn.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b>		MONTHS	DAYS	HOURS	MIN.	
10. CITY OR TOWN OF DEATH <b>ELLIOTT CITY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>at Home.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Government</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
13a. STATE <b>MD.</b>			13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Clarksville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>6521 GUILFORD ROAD</b>				<b>260 29</b>		
14. FATHER'S NAME FIRST <b>LEO FREDBRICK</b>			MIDDLE <b>-</b>	LAST <b>RETTGER</b>	15. MOTHER'S MAIDEN NAME FIRST <b>CLARA</b>				MIDDLE <b>Victoria</b>	LAST <b>SNYDER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-32-5867</b>			17. INFORMANT Son <b>John Rettger</b>				ADDRESS <b>65-104 Ave NW Coon Rapids MN. 55433</b>		
18. CAUSE OF DEATH (Enter only one cause per line for item 1a) and APPROXIMATE INTERVAL PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>EMPHYSEMA</b>												
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> <b>ON / A WHILE WORK</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>82</b>		CITY OR TOWN <b>3/18</b>	COUNTY	STATE	<b>86</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>86</b> to <b>3/18</b> , 19 <b>86</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <b>William Flowers</b>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/18/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM FLOWERS, M.D.</b>		22e. ADDRESS <b>11055 Little Patuxent Pkwy Columbia Md. 21044</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>March 21 1986</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>West View</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>1</b>	STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Harley H. Witte</b>		ADDRESS <b>Funeral Home Inc. 4112 Columbia Rd. E.C. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>BP</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 0 0 8 6 8 9						
										REG. NO.						
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Forrest			Riffle			March 6, 1986						8:55 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			July 24, 1917			68			YEARS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia			USA						Howard			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Clarksville			7500 Flamewood Drive						electrical engineer US Govt							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Howard			Clarksville						7500 Flamewood Drive 21029				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2			17. INFORMANT James Riffle same as above			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____			DUE TO, OR AS A CONSEQUENCE OF COPD, pulmonary and coronary obstructive pulm. disease (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Inhalation onto valve																
19a. DATE OF OPERATION:			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (s) this hospital attended the deceased from 1984 to 1986, and that (s) my (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 2/16/86 and that (s) (we) did not know the body after death.										22c. DATE SIGNED						
22b. SIGNATURE <i>Slater</i> DEGREE																
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. S. FMS</i>			22d. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 9, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Panorama Mem. Gardens			23d. LOCATION CITY OR TOWN Waterlick, Virginia COUNTY STATE							
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A.			ADDRESS Laurel, Maryland			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Ronelle</i>							
MAR 11 1986																

13100-00

RECORDED BY  
RADIO MOTION PICTURE

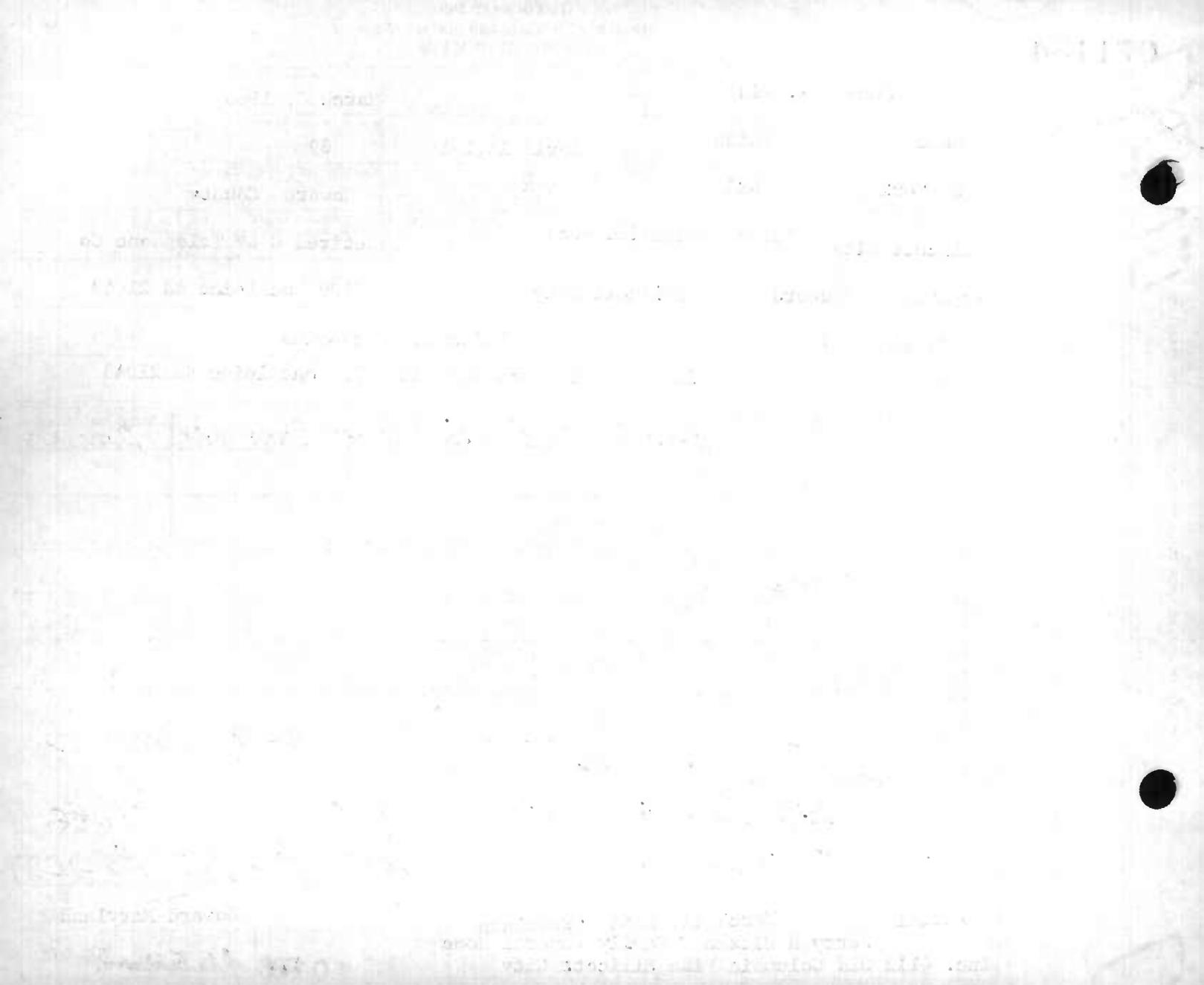
071154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial/tranfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, an other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			March 8, 1986			M			
Joseph E. Ring															
3. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR April 13, 1916			6. AGE (IN YEARS LAST BIRTHDAY) 69			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7. BIRTHPLACE STATE OR FOREIGN COUNTRY New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County			MD.			
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 3709 MacAlpine Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired C & P Telephone Co			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3709 MacAlpine Rd 21043			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph H Ring			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Garbarino												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212 05 0679			17. INFORMANT Mrs Ann Ring 3709 MacAlpine Rd 21043			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchitis obliterans Ca of lung &amp; brain mst</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DO TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>COPD</i>															
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from show the deceased alive on 3-1 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			1-17 19 86			to 3-8 19 86									
22b. SIGNATURE <i>Paul E. Gormley</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/10/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul E. Gormley</i>			22e. ADDRESS 900 Carson Ave Baltimore MD 21227												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 11, 1986 Crestlawn			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION COUNTY STATE Howard Maryland						
24. FUNERAL DIRECTOR NAME Inc. 4112 Old Columbia Pike Ellicott City			25a. DATE REC'D. BY REGISTRAR ADDRESS MAR 10 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>									



065039

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 8 6 9 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
CHARLES JAMES ROGERS						03	02	86	1 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
MALE		WHITE		MONTH APRIL DAY 26 YEAR 1929		56		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		U.S.A.				HOWARD COUNTY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
ELLIOTT CITY		9068-B TOWN & COUNTRY BOULEVARD		SALES REP.		AUTO				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLIOTT CITY		13e. STREET ADDRESS / ZIP CODE 9068-B TOWN & COUNTRY BLVD. 21043				
FATHER'S NAME FIRST JAMES		MIDDLE R.	LAST ROGERS	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH		MIDDLE LAST JAMES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. * 723/14/7312		17. INFORMANT C. JAMES ROGERS, JR.		9958 OAKLEA COURT ELLIOTT CITY, MD. 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21A				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)						21A 661C				
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 216		CITY OR TOWN 216		COUNTY 86		
22a. I certify that (I) (this hospital) attended the deceased from 2/26/86 to 3/5/86, that (I) (we) last saw the deceased alive on 2/26/86, and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death, check here)										
22b. SIGNATURE <i>Raymond D. Bonner</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond D. Bonner		22e. ADDRESS 5400 Jones						22c. DATE SIGNED 3/5/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5 MARCH 86		23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CEMETERY		23d. LOCATION CITY OR TOWN ELLIOTT CITY		COUNTY HOWARD		
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME ADDRESS ELLIOTT CITY, MD. 21043										
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner

615669



00-02495

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 08692

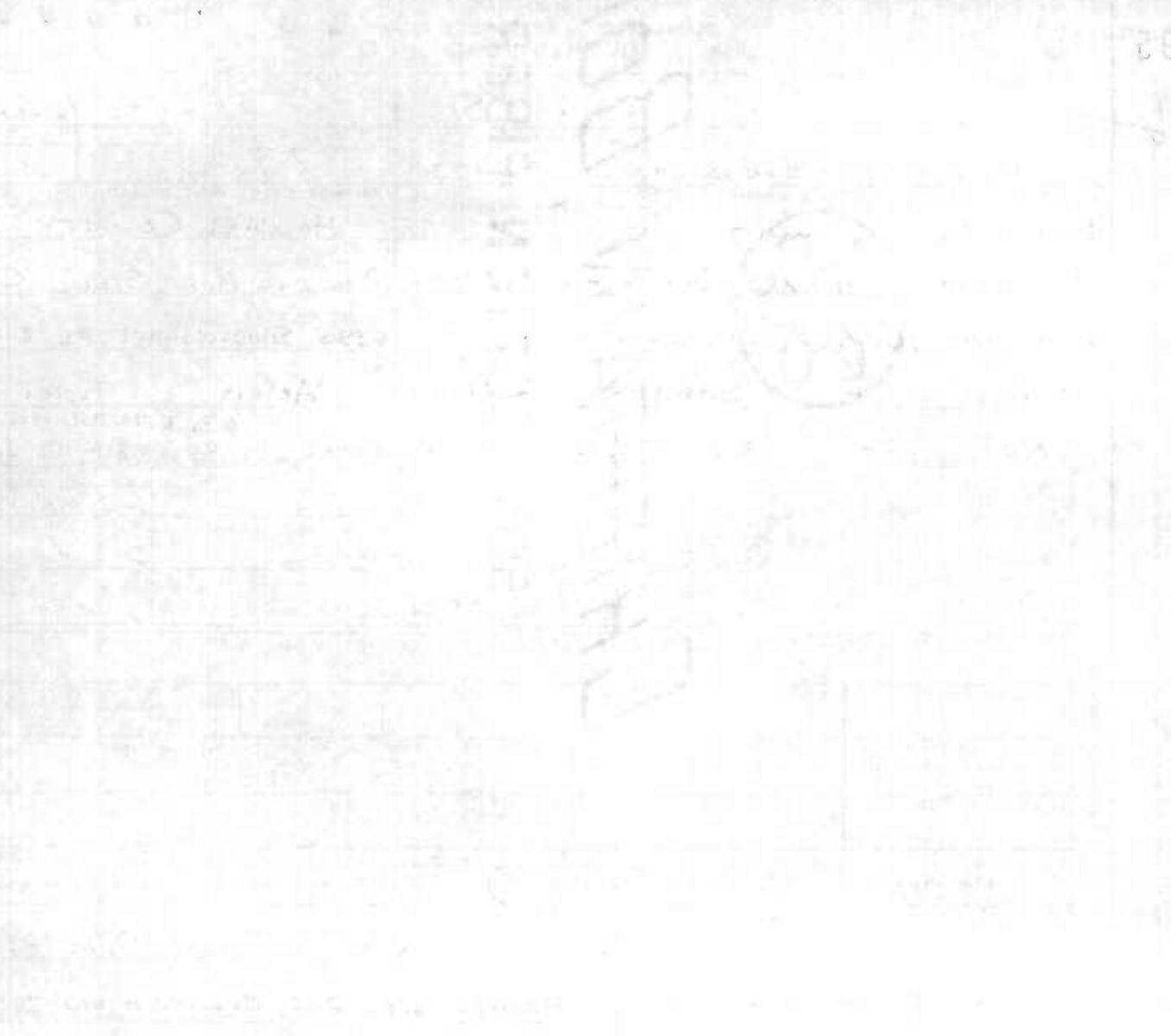
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon copies. Pages 3 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Donald M. Sawyer, Sr.</i>						<i>3</i>	<i>26</i>	<i>86</i>		<i>1240 AM</i>			
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS			
<i>Male</i>		<i>Caucasian</i>		MONTH <i>2</i>	DAY <i>26</i>	YEAR <i>09</i>	77	YRS <i>77</i>	MONTHS <i>0</i>	DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	
7b. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
<i>ILLINOIS</i>		<i>U.S.A.</i>								<i>HOWARD COUNTY MD.</i>			
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<i>COLUMBIA</i>		<i>HOWARD COUNTY GENERAL Hosp.</i>		<i>PERSONNEL MGR</i>		<i>STEEL CO.</i>							
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
<i>MARYLAND</i>		<i>HOWARD</i>		<i>COLUMBIA</i>				<i>6395 SHADOWSHAPE PL. 21045</i>					
14. FATHER'S NAME		FIRST <i>CHARLES</i>	MIDDLE <i>F.</i>	LAST <i>SAWYER</i>	15. MOTHER'S MAIDEN NAME		FIRST <i>Gertrude</i>	MIDDLE <i>Helen</i>	LAST <i>Tyler</i>	ADDRESS <i>6363 TINTED HILL COLUMBIA, MD 21045</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>NO</i>		<i>392-05-5276</i>				<i>Cardiogenic Shock</i>		<i>1-2 hours</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>						<i>2-3 days</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										<i>Years</i>			
19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT PLAY <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) this hospital attended the deceased from <i>3/26/86</i> , to <i>3/26</i> , 19 <i>86</i> , to <i>3/26</i> , 19 <i>86</i> , that (2) we last saw the deceased alive on <i>3/26/86</i> , 19 <i>86</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, check here.)													
22b. SIGNATURE <i>Jerome Hantman, MD</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/26/86</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JEROME HANTMAN, MD.</i>		22e. ADDRESS <i>MED. ARTS BLDG. #202, COLUMBIA, MD. 21044</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>26 MARCH 86</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>WESTVIEW MEM. PK.</i>		23d. LOCATION CITY OR TOWN <i>CATONSVILLE</i>		COUNTY <i>BALTO.</i>		STATE <i>MD.</i>			
24. FUNERAL DIRECTOR NAME <i>SLACK FUNERAL HOME</i>		ADDRESS <i>BOX 268 ELICOTT CITY, MD 21043</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 03 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Linda T. Johnson</i>							

20150-00



THE HOSPITAL CHILDREN'S CLINIC

hours after death. Page 4 may be

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached to the burial permit. Then please remove carbon copy pages 1 and 2 and be held with the burial permit until the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

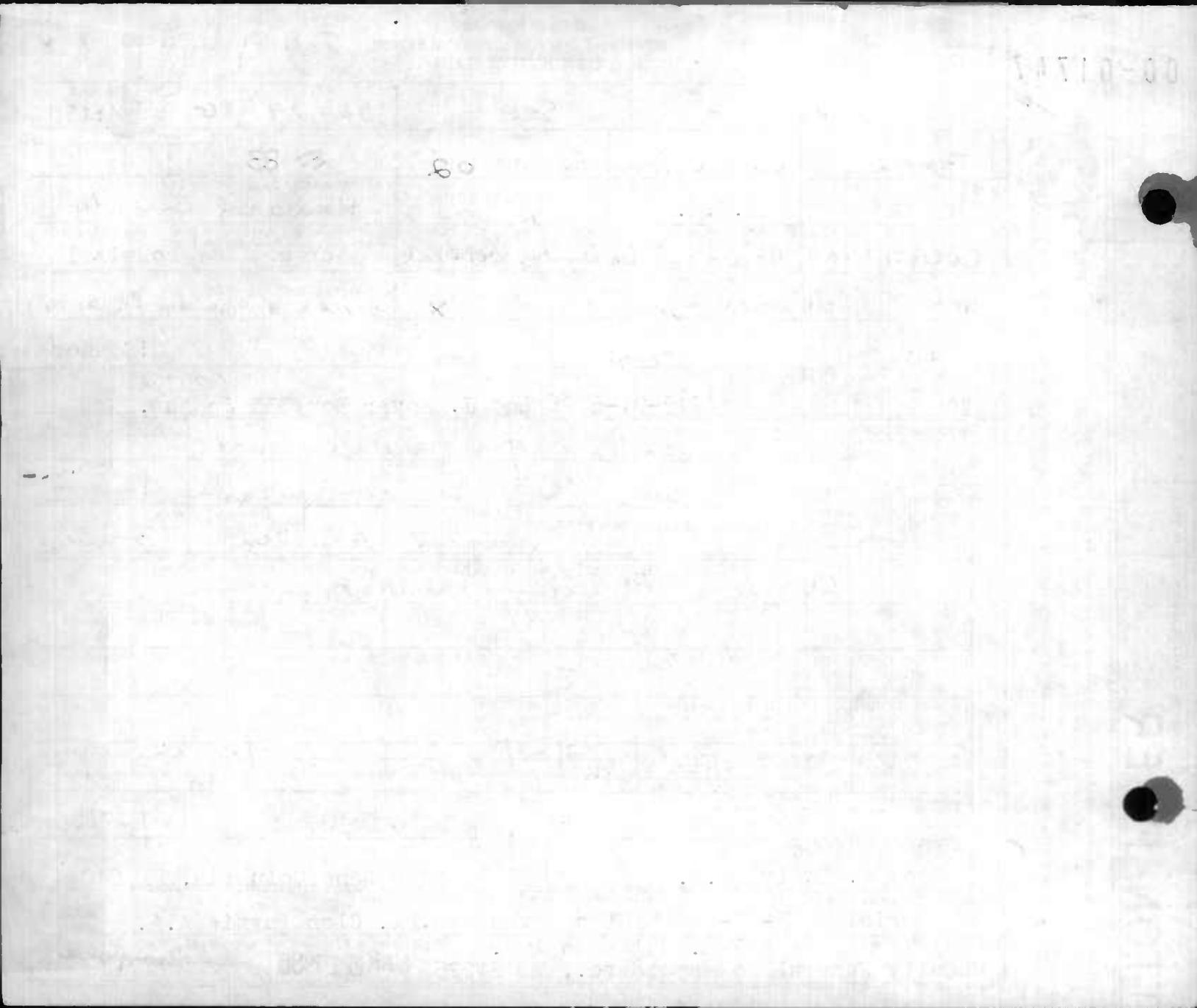
BP

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8608693

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
MARY			B	See		03-27-86				4:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	Caucasian	MONTH 02	DAY 30	YEAR 02		83 yrs	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Coleenbria	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b KIND OF BUSINESS OR INDUSTRY Hospital								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a STATE Md	13b COUNTY Howard	13c. CITY OR TOWN Jessup	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Box 28 Brockbridge Rd 20794	
14. FATHER'S NAME FIRST Salvador			MIDDLE	LAST Gepni	15. MOTHER'S MAIDEN NAME Emma	16. ADDRESS 20794 O'Connor					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 215-01-6006			17. INFORMANT Leo J. Moyer	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardio respiratory Failure								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis and Recurrent Aspiration pneumonia			1 month					
			DUE TO, OR AS A CONSEQUENCE OF (c) Left Cerebrovascular Accident			3 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
Chronic Atrial Fibrillation											
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET - CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 21 20 1986 to 3/27/1986, that (I) (we) last saw the deceased alive on 3/26/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE	DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/27/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS			5755 Cedar Lane Columbia, MD 21044							
Syed A. Sadiq M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem.Pk.			23d. LOCATION CITY OR TOWN Glen Burnie A.A.	COUNTY MD		STATE			
Burial	3-31-86										
24 FUNERAL DIRECTOR NAME McCullum Funeral Homes	237 E. Patapsco Ave. ADDRESS Balto., MD 21225			25a. DATE REC'D. BY REGISTRAR MAR 31 1986			25b. REGISTRAR'S SIGNATURE June L. Anderson-Henderson				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be deposited for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 0 8 6 9 4		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Michael Joe Steinback						March 29 1986						3:00 P.M.		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
male			caucasian		July 24 1941		44			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Arkansas			USA				Howard							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Laurel			9306 All Saints Rd.		Special Agent		FBI							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.			Howard		Laurel					9306 All Saints Rd. 20707				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Jewell			J.		Steinback	Virginia						Light		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			Rt. 1 Box 14			
no			432-76-8485		Virginia Steinback W. Helena, Arkansas									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardioscler Failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malnutrition</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Autoimmune Deficiency Syndrome</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1 1986</u> to <u>MARCH 20 1986</u> , that (I) (we) last saw the deceased alive on <u>MARCH 1 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>Michael L. Weinstein</u>		DEGREE			22c. DATE SIGNED 3/29/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
MICHAEL L. WEINSTEIN MD			916 19th St. NW WASHINGTON, DC 20006											
23a. BURIAL, CREMATION, REMOVAL (SPEC)			23b. DATE 3/30/86		23c. NAME OF CEMETERY OR CREMATORIAL Balto. Wash. Crematory			23d. LOCATION Laurel		COUNTY	STATE			
Cremation			3/30/86		Balto. Wash. Crematory			Laurel		P.G.	Md.			
24. FUNERAL DIRECTOR NAME			ADDRESS 7601 Sandy Spring Rd. Fleck Funeral Home Inc. Laurel, MD 20707					25a. DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE <u>June Henderson</u>			

31211-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial permit. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80008595				
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR							2b HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	3. DATE OF BIRTH MONTH DAY YEAR		4. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		5. IF UNDER 24 HRS. HOURS MIN.				
Nora E. Sterling						5 - 17 - 05		80 YRS		7:00 PM				
3. SEX			4. RACE	5. DATE OF BIRTH	6. CITIZEN OF WHAT COUNTRY?									
Female			White	MONTH DAY YEAR	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
7a. BIRTHPLACE NAME OF FOREIGN COUNTRY U.S.A.			7b. CITIZEN OF WHAT COUNTRY?	8. DATE OF BIRTH	9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland			U.S.A.	MONTH DAY YEAR	Howard County MD									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)				
Columbia			Lorien Nursing Home							Housewife				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							12b. KIND OF BUSINESS OR INDUSTRY		
Md.			Howard	Ellicott City	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							21043		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE							13e. STREET ADDRESS / ZIP CODE 9028 Town and Country Blvd				
Maurice Kirwan			Mary							Northam Blvd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.							17. INFORMANT ADDRESS				
No			820-01-7689							Susan Sterling 9028 B Town & Country				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Carcinoma of pancreas</i>														
DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____  (c) _____														
DUE TO, OR AS A CONSEQUENCE OF  (b) _____  (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive pulmonary disease</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19							21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/13/86 to 19/86, that (I) (we) lost saw the deceased alive on 3/30/86 19/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										22c. DATE SIGNED 3/31/86				
22b. SIGNATURE <i>Bruce Cooper MD</i>										DEGREE ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 3850 Health Park Drive Ellicott City, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/2/86	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Mem Phil Woodlawn Baltimore Md							23d. LOCATION CITY OR TOWN			
Burial			4/2/86	Lorraine Mem Phil Woodlawn Baltimore Md							COUNTY STATE 21043			
24. FUNERAL DIRECTOR NAME Joseph L. Ronby-West Friendship			25a. DATE REC'D. BY REGISTRAR APR 02 1986							25b. REGISTRAR'S SIGNATURE <i>John Pender</i>				

1985-0

WILSON LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 0 8 5 9 6

00-01371

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Blanche R</i>	MIDDLE <i></i>	LAST <i>Swiney</i>	2a. DATE OF DEATH MONTH <i>Aug.</i>	DAY <i>31</i>	YEAR <i>1986</i>	2b. HOUR <i>6 p.m.</i>		
3. SEX  Female			4 RACE  White	5. DATE OF BIRTH MONTH <i>Aug.</i>			DAY <i>31</i>	YEAR <i>1919</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>66</i>	IF UNDER 24 HRS MONTHS <i>YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MD. <i>Howard County</i>		
10. CITY OR TOWN OF DEATH <i>Columbia</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General Hosp.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) <i>Packer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Bartis Bros.</i>		
13a. STATE <i>MD.</i>			13b. COUNTY <i>Howard</i>	13c. CITY OR TOWN <i>Ellicott City</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>3017 N. Rogers Ave. 21043</i>			
14. FATHER'S NAME FIRST <i>Edward</i>			MIDDLE <i></i>	LAST <i>Williams</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Minnie</i>			MIDDLE <i></i>	LAST <i>Gibson</i>	ADDRESS <i>3017 N. Rogers Ave. Ellicott City, MD 21043</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>- 220-12-6382</i>			17. INFORMANT <i>James E. Swiney</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Arrhythmias Hypoxic asphyxia</i>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a (c) <i>Ischemic Cardiomyopathy</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Arrhythmias Hypoxic asphyxia</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ischemic Cardiomyopathy</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) saw deceased alive on 3 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 21 21, 19 86, to 3 19, 19 86, that (I) (we) last saw the deceased alive on 3 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death			22b. SIGNATURE <i>Stephen V. Lentz Jr.</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>3/19/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN V. LENTZ JR.</i>			22e. ADDRESS <i>Howard County Hospital</i>								
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>24 March 86</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Good Shepherd Cem.</i>			23d. LOCATION OR TOWN <i>Ellicott City Howard MD</i>		
24. FUNERAL DIRECTOR NAME <i>Shack Funeral Home</i>			ADDRESS <i>3017 263 Ellicott City, MD 21043</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1986</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Shanahan</i>		

17810-90

17810-90  
17810-90

00-00331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please return to the medical examiner's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 8 6 9 7					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
EMMA			B		THOMPSON	3 10 86			10 20	P	PM				
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.			
FEMALE		W		4 02 90			94			YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD		USA					HOWARD								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
COLUMBIA		LORIEN NURSING HOME										HOMEMAKER		DOMESTIC	
13a STATE		13b COUNTY		13c. CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE					
MARYLAND		HOWARD		COLUMBIA			YES <input type="checkbox"/> NO <input type="checkbox"/>			9212 BERGER RD. 21046					
14 FATHER'S NAME FIRST		MIDDLE		LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
EDWARD		E		BEALMEAR			FLORENCE					HARMAN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		(YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO				215-48-1680			PHILLIP S.C. THOMPSON			9212 BERGER RD. COLUMBIA, MD. 21046		immed			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY															
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u>															
19 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED								20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19								21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)								21f LOCATION STREET		CITY OR TOWN COUNTY STATE			
22a I certify that (I) (We) attended the deceased from <u>1980</u> to <u>1986</u> , that (I) (We) last saw the deceased alive on <u>2</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.															
22b SIGNATURE		DEGREE								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE)										22e ADDRESS		11 MAR 86			
ALAN STAHL, MD										2 KROLL NORTH, COLUMBIA, MD 21045					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN		23e COUNTY		23f STATE				
Burial				LOUDON PARK CEM.			BALTIMORE CITY		MD.						
24 FUNERAL DIRECTOR NAME		ADDRESS								25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
SLACK FUNERAL HOME		Box 268 ELLIOTT CITY, MD 21049								MAR 14 1986		Sister Barbara Pendell			
DHMH - 16 60M 7-B4 (VRA 15, 4)															

09-00331



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Failure to do so may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	08698			
										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	March 16, 1986			~ 7:33 AM					
JOHN L. WEEKS														
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Male			White		February 5, 1930			56 yrs.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS.			
New York			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard County			MONTHS DAYS HOURS MIN.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (INCLUDE SPECIAL FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Ellicott City			2910 Ebbwood Drive							Marketing Service			Westinghouse Manager	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION: GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland			Howard		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2910 Ebbwood Drive 21043					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
Llewellyn				Weeks	Gladys				Bollow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes			Korean		134-20-6548			Marie O. Weeks			Same as # 13		Minutes	
18. CAUSE OF DEATH: Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>													Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.													Days	
{ (b) <u>ischemic cardiomyopathy, arrhythmia</u>													Months	
{ (c) <u>Coronary artery disease</u>													Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (this hospital) attended the deceased from 6/13/85 to 2/19/86, and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated below. I (we) lost														
saw the deceased alive on 2/14/86, and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Stephen Valenta M.D.</u>			DEGREE							22c. DATE SIGNED 3/17/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
Stephen Valenta M.D.			22e. ADDRESS Suite 202 11085 Patuxent Parkway, Columbia, MD. 21044											
23a. BURIAL, CREMATION, REMOVAL SPECIFY			23b. DATE 3/20/86		23c. NAME OF CEMETERY OR CREMATORIAL St. Alphonsus			23d. LOCATION CITY OR TOWN Woodstock		COUNTY	STATE Maryland			
Burial														
24. FUNERAL DIRECTOR LeRoy M. & Russell C. Withz Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, MD. 21045								25a. DATE REC'D. BY REGISTRAR MAR 17 1986		25b. REGISTRAR'S SIGNATURE <u>John L. Valenta</u>				

